

Correspondence

Ethical issues of a doctors' strike

SIR

The two recent papers on the ethical aspects of a doctors' strike in this journal (1, 2) were timely for us in New Zealand where the junior doctors have been considering 'industrial action' for some time. Both papers, however, fell short on key arguments. Brecher (1), although convincing in his argument on the relative material valuation of life, largely skirted the issue of the special nature of the physician-patient contract and the entailed moral obligations. Grosskopf *et al* (2) were almost apologetic in their article although the Israeli doctors had such a strong case for a strike, were acutely aware of their ethical responsibilities and had a broader perspective of the doctor-patient contract. I think the key questions in the ethical debate on a strike by doctors are: a) Can the long-term benefits to the doctors and the public offset the short-term costs to the latter, including avoidable death? b) Can immediate needs be set aside in anticipation of future benefit? c) Does the nature of the physician-patient or physician-society contract preclude strike action? and d) How would a strike affect the public image of doctors?

In the public health system, situations can arise when the working conditions of the doctors are so bad that a strike becomes understandable. Does that also make it morally conscionable? Even if life is measured in relative terms, a moral justification for a strike exists only if the long-term benefits to the physicians and their families are great, the health-care delivery improves considerably as a result, more lives are possibly saved in the long run and the benefits are passed on to the physician-less members of the society (3). Less stringent criteria need to be applied if a case can be made that doctors are being

exploited, something more likely to happen to junior doctors (4) or in socialised medicine (1). Some moral dilemmas can be bypassed by limiting a strike so that emergency care does not suffer and it merely results in the prolongation of waiting lists already existing because of inadequate facilities.

The central argument, however, is the nature of the physician-patient contract. A doctor has a special contract with an individual patient s/he accepts for treatment and is morally bound to provide continuing care or transfer to another competent physician. The doctor cannot be said to have a special obligation towards individuals who might become his patients in the future were s/he to continue practising medicine, or never to be absent from work or fall ill or cancel an appointment for any other reason. S/he has a contract with society to act responsibly when s/he 'is there' but is not bound to be always available 'under any circumstances'. Moreover, in countries where medicine is largely socialised, the provision of health care is the joint responsibility of the physician, the hospital and the government. The contract, therefore, has multiple arms. If, for example, the hospital fails to meet its contract with the physician, the sanctity of the other limbs of the contract suffers. Furthermore, as doctors change from healers to technocrats and the doctor-patient relationship becomes less paternalistic with patients becoming more litigious and doctors more defensive, the nature of the contract will be further altered. It is clear that this concept of the physician-patient contract makes strike action ethically more justifiable.

Provided doctors are reasonable in their demands, a strike can only make them seem human! Little harm can accrue from shattering a somewhat antiquated myth of sainthood and injecting a good dose of realism (3).

References

- (1) Brecher R. Striking responsibilities. *Journal of medical ethics* 1985; 11: 66-69.
- (2) Grosskopf I, Buckman G, Garty M. Ethical dilemmas of the doctors' strike in Israel. *Journal of medical ethics* 1985; 11: 70-71.
- (3) Veatch R M. Interns and residents on strike: commentary. *The Hastings Center report* 1975; 5(6): 7-9.
- (4) Anonymous. Hours 'justify overtime pay'. *Otago Daily Times* 1985 Sept 4: 5 (cols 8-10).

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[See also pages 40-44. Editor]

Acts and omissions doctrine and abortion: reply to Dr Toon

SIR

Dr Toon (1) rightly points out that tradition asserts a difference between actively killing and letting die. In certain instances it seems permissible to let die because of the inabilities of physicians, for example, to treat certain conditions. One wonders therefore if the precarious conditions of 'persons' at risk for spontaneous abortion would similarly legitimise letting them die.

First of all, it seems to me that this distinction does little to explain why persons subject to spontaneous abortion are systematically excluded from the benefits of medical research and practice. On the face of it, it seems that we would have as much obligation to

this group of persons as any other group which could be the object of medical interest. If it is not *in fact* possible to prevent spontaneous abortion, then it might seem that fate has absolved us of any moral responsibility. But if the causes and treatment of such abortion are *in principle* discoverable, then it seems that one has the same kind of obligation to persons at risk for spontaneous abortion as one has for any other kind of life-endangering disease.

Could one argue, because of other considerations and possible costs, that one might still legitimately let these persons die? One might, but that kind of argument would presuppose the existence of an ordinary moral obligation to be treated but that this obligation was dissolved by some other more pressing obligation. An argument that the moral permissibility of letting die would cover persons at risk for spontaneous abortion therefore would, it seems to me, be convincing only if there were evidence that nothing could *in principle* be done for these persons. It seems to follow therefore that it would be morally desirable to research the causation and treatment of spontaneous abortion not only to render the strict anti-abortion argument consistent but also to discover whether or not there would be conditions legitimately grounding practices of letting die.

Reference

- (1) Toon P D. Letter. Acts and omissions doctrine and abortion. *Journal of medical ethics* 1985; 11: 217.

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Service and the medical profession

SIR

I would like to comment on an exigent issue – the concept of ‘service’ as being critical to the medical profession – which was mentioned in the June issue of the journal, both in the editorial and in the article by Dr Dyer (1).

‘Service’ (for example, caring, compassion, listening to the patient, being interested in the patient’s personal life, giving the patient sufficient time to his satisfaction and needs, and establishing a mutually trusting relationship) is more than the abstract altruism which you suggest it to be.

In fact, ‘service’ – in all its connotations and nuances – is a skill, one requiring time and effort, and a giving of oneself; but because of indifference it does not receive any professional recognition worth mentioning, nor does it receive any remuneration commensurate with its value; rather this service ideal which you so rightly consider essential, is considered by the public, and by many within our profession, as ‘bedside manner’; as part of the physician’s personality. In other words, it is taken for granted.

In the context of today’s complex world of high accountability with the need to meet patients’ expectations, and the highly intricate nature of medical care, the ideal of service requires much more time and effort, and places more stress on the physician than it ever has before.

Seen in this light, ‘service’ as a skill has expanded in complexity along with the general body of medical knowledge

and medical technique; though the concept of service may not be as dramatic as a surgical technique, or an endoscopic procedure, it is every bit as important to taking care of sick people.

If we are to exhume the service ideal and restore it to its rightful place in the medical hierarchy (at the top of the list, not the bottom) then two conditions will have to be fulfilled i) the ‘service ideal’ must be recognised as a skill, as valuable as any technical skill is and ii) the service ideal must receive proper remuneration.

If we in the medical profession do not make an effort to recognise the concept of service – some would call this ‘cognitive service’ – as valuable and important to the practice of medicine, then indeed medicine will have lost an important opportunity to maintain its professional status.

Reference

- (1) Anonymous. Medicine, profession and society [editorial]. *Journal of medical ethics* 1985; 11: 59–60. Dyer A R. Ethics, advertising and the definition of a profession. *Journal of medical ethics* 1985; 11: 72–78.

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